No. 89-1679

In The

Supreme Court of the United States

October Term, 1990

SUMMIT HEALTH, LTD., et al.,

Petitioners,

vs.

SIMON J. PINHAS, M.D.

Respondent.

BRIEF OF RICHARD A. BOLT, M.D., AS AMICUS CURIAE SUPPORTING RESPONDENT

CLARK C. HAVIGHURST
c/o Duke University
School of Law
Science Drive and
Towerview Road
Durham, North Carolina 27706
(919) 684-8152

HAL K. LITCHFORD*
KEVIN D. COOPER
LITCHFORD, CHRISTOPHER &
MILBRATH, P.A.
One duPont Centre
Suite 2200
P.O. Box 1549
Orlando, Florida 32802
(407) 422-6600

*Counsel of Record

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

TABLE OF CONTENTS

TABLE OF CONTENTS – Continued

TABLE OF AUTHORITIES

TABLE OF AUTHORITIES – Continued

TABLE OF AUTHORITIES – Continued

STATUTES

MISCELLANEOUS

TABLE OF AUTHORITIES – Continued

INTEREST OF THE AMICUS CURIAE

Richard A. Bolt, M.D., is the plaintiff in an antitrust action currently awaiting a second trial in the District Court for the Middle District of Florida. Dkt. No. 82-122-ORL CIV 18. *See also Bolt v. Halifax Hosp. Med. Center*, 891 F.2d 810 (11th Cir.), *cert. denied*, 110 S. Ct. 1960 (1990). In that proceeding, he alleges (1) an unlawful group boycott by the three hospitals in Daytona Beach, together with certain physicians, to deny him admitting privileges in the community and (2) separate unlawful conspiracies within two of the hospitals to deny him privileges in those institutions. Partly because his burden of proof at the retrial of his Sherman Act case may be adversely affected by this Court's decision in this case, but also out of concern for the public interest, he respectfully submits this brief amicus curiae. Pursuant to Supreme Court Rule 37.3, Dr. Bolt has received the written consent of all Petitioners and Respondent to file this brief. Copies of these consents are submitted herewith.

The Eleventh Circuit currently adheres to a jurisdictional requirement similar to the Ninth Circuit's standard that is challenged by the Petitioners in this case. *See Shahawy v. Harrison*, 778 F.2d 636, 638-41 (11th Cir. 1985). Thus, any stricter jurisdictional standard that this Court may announce in this case would increase Dr. Bolt's burden of proof in the retrial of his case. Dr. Bolt's primary concern, however, is that the scanty pleadings of the Respondent and brief opinion of the court of appeals in this case may not sufficiently demonstrate the importance of maintaining federal antitrust oversight of actions taken by the medical staffs of hospitals. On the basis of personal observation, Dr. Bolt shares the view of many

other knowledgeable observers[1] that medical staffs administering admitting privileges in hospitals regularly use their powers, not to maintain the quality of care, but to restrain trade and to advance other interests of their physician members at the expense of consumers and of the hospitals they purport to serve.

SUMMARY OF ARGUMENT

This case has important implications for the application of section 1 of the Sherman Act, 15 U.S.C. § 1, to concerted acts of competing physicians in hospitals. Although each antitrust suit challenging an action by a hospital medical staff against an individual physician or other health care practitioner may seem insignificant in itself, many relatively minor violations can add up to a serious cumulative injury to interstate commerce. It is submitted that cases like the instant one represent the tip of an iceberg of abuse by physicians of hospital-granted powers and thus have serious implications for interstate commerce and competition in the $650 billion-a-year health care industry. Because Congress, in passing the Sherman Act, meant to exercise to the fullest possible extent its constitutional power to protect consumers, the Ninth Circuit's test for jurisdiction in hospital staff-privileges cases should be upheld.

The very existence of a combination of physician competitors empowered to decide the fate of other physicians, as well as other issues affecting competition in

[1] *See* note 12 *infra*.

their own market, endangers interstate commerce and cries out for federal antitrust scrutiny. The court of appeals acknowledged as much in this case by holding that "[peer-review] proceedings affect the entire staff at Midway [Hospital] and thus affect the hospital's interstate commerce." This holding is consistent with the decisions of this Court because, "as a matter of practical economics," the activities of physicians on hospital medical staffs are "infected" by inherent conflicts of interests and a propensity to restrain trade. The court of appeals was therefore correct in holding that the jurisdictional test in staff-privileges cases should focus on the effects of such "infected" activities and not only on the significance of the individual physician plaintiff who somehow ran afoul of the medical staff.

Claims by hospital and physician interests that the threat of antitrust suits deters responsible peer review and quality assurance in hospitals need not be taken seriously, because a hospital and its medical staff can escape close antitrust scrutiny of their peer-review activities by arranging their joint venture differently. If the decision on staff privileges is genuinely made by the hospital alone – that is, by an entity standing in a vertical market relationship to the physician, rather than by his horizontal competitors –, no real antitrust issue even arises. Even though most plaintiffs will allege that they were victims of a hospital/staff conspiracy, this Court has developed principles for screening such problematical allegations of conspiracy so that they will not deter procompetitive conduct. Under these principles, a plaintiff's case should be dismissed unless he can offer "evidence that tends to exclude the possibility that [the hospital was] acting independently" in its own commercial interest and not in collusion with its physicians.

As long, however, as decision making in a hospital remains infected by the medical staff's inherent conflict of interests, federal antitrust oversight is needed to ensure that the staff's delegated powers are not being abused at the expense of competitors and consumers. Such oversight should not be blocked by a jurisdictional requirement that focuses only on the effects of the action taken against one individual plaintiff. Consumers have much more at stake in cases of this kind than their interest in the fate of a single competitor.

ARGUMENT

I. The jurisdictional test applied by the Ninth Circuit in this case, because it recognizes the pervasive impact of the activities of organized medical staffs in hospitals, fully comports with the "practical-economics" test laid down in decisions of this Court.

Neither the plaintiff's complaint nor the opinion of the court of appeals in this case devotes much space to establishing Sherman Act jurisdiction. Both the plaintiff and the court apparently assumed that the jurisdictional test for antitrust cases challenging actions taken by a hospital medical staff against a single physician competitor was clear and easily satisfied. In opening the issue of jurisdiction for further consideration, this Court should be willing to consider the wide range of considerations, besides those expressly mentioned by the court of appeals, that support jurisdiction in this case. Specifically, the Court should recognize that the organized medical staffs of American hospitals have sweeping responsibilities and powers that unavoidably impact interstate

commerce at many points. This obvious fact, which the court of appeals said "can hardly be disputed," supports the court's conclusion that "[peer-review] proceedings affect the entire staff at Midway [Hospital] and thus affect the hospital's interstate commerce." This Court's decisions concerning the application of the Sherman Act to professional services clearly support finding the requisite jurisdictional nexus in virtually any staff-privileges case.

A major reason why the federal antitrust laws were almost never applied to the so-called "learned professions" prior to this Court's 1975 decision in *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975), was that professionals were viewed as being engaged exclusively in localized activities unlikely to affect interstate commerce. In *Goldfarb*, however, the Court held that even highly localized professional services (title searches by attorneys) could be subject to the Sherman Act if they were an essential, integral, and inseparable part of interstate transactions (real estate financing). In *McLain v. Real Estate Bd. of New Orleans*, 444 U.S. 232 (1980), the Court went further still, finding jurisdiction even though the local professional activity involved (real estate brokerage) was not inseparable from the interstate activity it affected. The Court required only that "respondents' activities which allegedly have been infected by a price-fixing conspiracy be shown 'as a matter of practical economics' to have a not insubstantial effect on the interstate commerce involved." *Id.* at 246, quoting *Hospital Building Co. v. Trustees of Rex Hosp.*, 425 U.S. 728, 745 (1976). Petitioners had only "to demonstrate a substantial effect on interstate commerce generated by respondents' brokerage activity." 444 U.S. at 242. It was not necessary to

show interstate effects caused by the allegedly illegal conduct itself.

The instant case appears to raise simply the question how the *McLain* test should be applied in cases involving actions taken by organized medical staffs in hospitals against individual physician competitors. Medical staffs occupy such central positions in hospitals, however, that their activities would appear to satisfy even the more stringent *Goldfarb* standard. Thus, the Ninth Circuit's holding in this case might be read as a recognition that a hospital medical staff is "an essential, integral, part of the [hospital enterprise] and inseparable from its interstate aspects." *Goldfarb*, 421 U.S. at 240 (paraphrased). If federal law could reach the localized activities of lawyers that were challenged in *Goldfarb*, there should be no constitutional impediment to applying it to actions of physician organizations taken as agents of hospitals engaged in interstate commerce. Because Congress meant to exercise its constitutional powers to the fullest when it adopted the Sherman Act, *Apex Hosiery Co. v. Leader*, 310 U.S. 469, 495 (1940), the Ninth Circuit's jurisdictional test for staff-privileges cases should be upheld.

Because this Court focused in *McLain* on the effects of the defendants' allegedly "infected" activities rather than the effects of the specific practices alleged as violations, some courts have suggested that jurisdiction exists in a staff-privileges case if the "general business activities" of the defendant hospital affect commerce.[2] Although this

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[2] *Shahawy, supra*, 778 F.2d at 638-41; *Cardio-Medical Assocs. Ltd. v. Crozer-Chester Med. Center*, 721 F.2d 68, 71-76 (3d Cir.

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view would probably be defensible as a constitutional matter, the court of appeals in this case did not take such an extreme position.[3] But neither did it focus narrowly, as some courts have done,[4] solely on the impact on interstate commerce of the injury done to the particular physician plaintiff. Instead, the court of appeals took an intermediate position, finding jurisdiction on the basis that the specific activity within the hospital that the plaintiff alleged to be infected by an anticompetitive animus – the activities of the hospital's medical staff in conducting peer review – had a high probability of affecting commerce. This ruling is entirely consistent with *McLain* because Respondent's complaint adequately alleged that an anticompetitive motive and purpose "infected" peer-review activities at Midway Hospital and because, "as a matter of practical economics," those activities inevitably impacted interstate commerce.

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1983); *Hahn v. Oregon Physicians Serv.*, 689 F.2d 840, 844 (9th Cir. 1982). *Cf. Western Waste Serv. Systems v. Universal Waste Control*, 616 F.2d 1094 (9th Cir. 1980).

[3] It is arguable that, despite some loose dictum, no court has upheld jurisdiction without some basis for believing that the challenged conduct itself would have some effect on the defendant's interstate business. This point is helpfully developed in Respondent's Brief in Opposition to the Petition for a Writ of Certiorari, at 4-10.

[4] *E.g., Stone v. William Beaumont Hosp.*, 782 F.2d 609 (6th Cir. 1986); *Seglin v. Esau*, 769 F.2d 1274, 1279-81 (7th Cir. 1985); *Hayden v. Bracy*, 744 F.2d 1338, 1342-43 (8th Cir. 1984); *Furlong v. Long Island College Hosp.*, 710 F.2d 922, 925-28 (2d Cir. 1983); *Crane v. Intermountain Health Care, Inc.*, 637 F.2d 715, 720-27 (10th Cir. 1981); *Thompson v. Wise Gen. Hosp.*, 707 F.Supp. 849 (W.D.W. Va. 1989).

II. Because competition and consumer welfare are in jeopardy whenever combinations of physician competitors exercise the powers of hospitals, the test for Sherman Act jurisdiction in staff-privileges cases must focus on more than the injury suffered by an individual competitor.

Petitioners argue that, in any staff-privileges case, the individual plaintiff should be required to prove that the harm resulting to him as an individual from the alleged violation has significant consequences for interstate commerce.[5] Antitrust law, however, is concerned with "competition, not competitors," *Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477, 488 (1977), and therefore should not focus only on the fate of a single individual. The Ninth Circuit's test, acknowledging the anticompetitive hazards and potential for interstate impact inherent in medical staff peer-review actions, is therefore in keeping with antitrust courts' responsibility for protecting consumer welfare. The Ninth Circuit's finding of a nexus with interstate commerce is also supportable because of the special opportunities for abuse that arise when

[5] Although some cases appear to require such proof, *see* note 4 *supra*, perhaps the best-reasoned statement of the "majority" rule, *Furlong*, *supra*, indicated that it would be sufficient if the plaintiff had alleged "facts from which it is inferable that the defendants' activities, infected with the particular illegality alleged, are likely to have a substantial effect on commerce." 710 F.2d at 927. Under this approach, allegations that a medical staff was generally infected with an anticompetitive purpose would be sufficient. The Ninth Circuit test simply recognizes the reality that medical staff activities are always infected with such a conflict of interests.

combinations of physicians exercise *de facto* control over professional practice in a hospital. A medical staff that is left free by a hospital to pursue its members' collective interests should certainly not have its actions in individual cases immunized from antitrust scrutiny just because they affect only one competitor at a time.[6]

A. The organized medical staffs of hospitals are "infected" by conflicts of interests and have both the propensity and many opportunities to restrain trade and interstate commerce. They should therefore be subject, without more, to Sherman Act jurisdiction.

Many essential managerial tasks in hospitals are carried out by competing physicians collaborating under the auspices of an organized medical staff. Ideally, a hospital medical staff would operate as just another administrative arm of the hospital, serving only hospital objectives. Nevertheless, because a typical medical staff operates under its own by-laws, elects its own officers, and appoints its own committees, it is only remotely under the authority of and accountable to the hospital's governing board. Although the hospital board retains the power

[6] *See generally* Havighurst, "Doctors and Hospitals: An Antitrust Perspective on Traditional Relationships," 1984 Duke L.J. 1071, 1142-44 ("Despite the plausibility of the more demanding view of the jurisdictional requirement in privileges cases, the analysis presented above should point to adoption of the more liberal position. The focus in that analysis on decisionmaking processes in individual hospitals suggests that the relationships to be examined substantively in each case are likely to have repercussions transcending the harm to any particular plaintiff.").

to approve the staff's by-laws and to disapprove particular actions the staff may take, it usually cannot discipline individual physicians directly or appoint officers to exercise direct authority over physicians. A hospital medical staff is thus a unique organization-within-an-organization.[7] Because of its insulation from effective corporate control, it cannot be assumed that its actions consistently and reliably serve the interests of the hospital rather than the collective interests of its members.[8]

Hospitals are internally organized in this unique way, not because the traditional model has been proved superior under all circumstances, but largely because physicians have acted collectively to secure their powerful position in hospitals.[9] The basic organizational model – and especially the crucial requirement of staff "self-governance"[10] – has long been mandated by the accreditation

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[7] *See id.* at 1084-92, 1116-22.

[8] For this reason, courts have appropriately held that a medical staff is not such an integral part of the hospital that it is incapable of conspiring with it. *Oksanen v. Page Mem. Hosp.*, 1990-2 Trade Cases (CCH) para. 69,138, at 64,237-38 (4th Cir., Aug. 9, 1990); *Bolt*, 891 F.2d at 819-20; *Oltz v. St. Peter's Community Hosp.*, 861 F.2d 1440, 1450 (9th Cir. 1988). This Court denied review of the *Bolt* holding on this important point. 110 S. Ct. 1960 (1990). The correct conceptualization is that a hospital and its self-governing medical staff are engaged in a joint venture to operate the facility. *See* section III *infra*.

[9] *See* Havighurst, *supra* note 6, at 1087-92.

[10] *See, e.g.*, Joint Commission on Accreditation of Hospitals, Accreditation Manual for Hospitals/1988 at 47-50, 111-29 (1987) (especially Standard MS.2, contemplating a "framework of self-governance," a phrase that was readopted after being omitted from manuals for 1984 and 1985).

requirements of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), an organization dominated by the three most powerful professional organizations of physicians.[11] This sponsorship has yielded organizational requirements that effectively maintain *de facto* physician authority in hospitals. Although the JCAHO model of the hospital is well accepted – and can be an effective way of enlisting physicians to exercise responsibility for the work of their fellow professionals –, it nevertheless carries many risks to competition. Many commentators have expressed the view that, despite appearances and the observance of legal forms (which the JCAHO's standards also observe), most hospital governing boards have tended to delegate *de facto* decision-making authority on many issues to their medical staffs rather than merely relying on them for advice in exercising responsibility for the care provided in the institution.[12]

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[11] *See generally* Jost, "The JCAH: Private Regulation of Health Care and the Public Interest," 24 B.C.L. Rev. 835 (1983); Havighurst & King, "Private Credentialing of Health Care Personnel: An Antitrust Perspective" (pt. 2), 9 Am. J.L. & Med. 264, 314-25 (1983) (arguing that the JCAHO should be subject to antitrust scrutiny as a joint venture that monopolizes the supply of authoritative information concerning the quality of hospitals).

[12] *E.g.*, P. Starr, The Social Transformation of American Medicine 162-79, 215-32, 428-49 (1982); Blumstein & Sloan, "Antitrust and Hospital Peer Review," Law & Contemp. Probs., Spring 1988, at 7, 10-24, 90 ("Physicians have exerted great influence on hospital decision making . . . and physicians holding staff privileges have had opportunities to use their power for anticompetitive purposes . . . . "); Havighurst, *supra* note 6, at 1116-22; Note, "Sherman Act 'Jurisdiction' in Hospital Staff Exclusion Cases," 132 U. Pa. L. Rev. 121, 123, 139-41

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In deciding this case, this Court must be mindful of the many ways in which a hospital medical staff, when not closely overseen by a hospital governing board, may restrain trade.[13] The most obvious source of antitrust concern is the medical staff's ability to limit the number of competitors in a given specialty by applying unreasonable or discriminatory standards to those whom they desire to exclude or eliminate. Although there may be other hospitals in the community to which an excluded physician could theoretically apply for privileges, a denial at one institution often serves (as Respondent has

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(1983); Kissam, Webber, Bigus & Holzgraefe, "Antitrust and Hospital Privileges: Testing the Conventional Wisdom," 70 Calif. L. Rev. 595, 603-10 (1982); Drexel, "The Antitrust Implications of the Denial of Hospital Staff Privileges," 36 U. Miami L. Rev. 207, 222-224 (1982); Dolan & Ralston, "Hospital Admitting Privileges and the Sherman Act," 18 Hous. L. Rev. 707, 727 (1981); Pauly & Redisch, "The Not-for-Profit Hospital as a Physicians' Cooperative," 63 Am. Econ. Rev. 87 (1973).

[13] Petitioners' simplistic claim that peer review, in general, is "not an economic activity," Brief for Petitioners, at 17-18, is simply erroneous "as a matter of practical economics." Moreover, it is not supported by the congressional committee report cited as its source. H.R. Rep. No. 99-903, 99th Cong., 2d Sess. 3 (1986). The committee's only point was that physicians do not stand to gain economically from engaging in peer review and are therefore easily deterred from engaging in it by fears of antitrust liability. Although it is true that physicians may be deterred from acting aggressively in the face of litigation threats, not all peer review is undertaken purely voluntarily. In hospitals, for example, the duty to participate in peer-review activities arises out of the physician's contract with the hospital and is a responsibility assumed as a quid pro quo for the privilege of admitting patients.

clearly alleged in this case) as a signal to medical staffs at other institutions that an individual is *persona non grata*. Even if the other hospitals are not dominated by their physicians to the same degree, they may reject a physician because of perceived liability risks in accepting someone whose privileges were terminated, whether deservedly or not, at another institution.[14]

A medical staff may also use its disciplinary powers selectively to ensure compliance with expectations unrelated to the hospital's business objectives. Thus, a physician who competes too aggressively must fear retaliation by his professional colleagues, who may decide on this irrelevant ground that there is a need to "review his charts." Physicians may thus be discouraged from advertising, from price cutting, or from cooperating with emergent competitors, such as health maintenance organizations, that threaten the economic interests of incumbent professionals.

Finally, a hospital medical staff can also control the manner in which specific professional services are provided, depriving individual physician competitors of the power to make such decisions independently. Indeed, the assistant-surgeon requirement at Midway Hospital, which the mistreatment of Dr. Pinhas was allegedly designed to enforce, appears to be an excellent illustration of the kind of naked, unjustified restraint of trade

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[14] Hospitals have often been held subject to liability for negligence in permitting physicians with doubtful credentials to practice in their facilities. *E.g., Elam v. College Park Hosp.*, 132 Cal. App. 3d 332, 183 Cal. Rptr. 156 (1982) (citing cases).

that an organized medical staff can impose when a hospital delegates to it powers properly exercised only by the hospital itself.[15] According to the complaint, Dr. Pinhas was able to perform high-quality eye surgery without assistance and sought only to compete by providing a more efficient service. Members of the medical staff, however, had an interest in protecting the income they could earn by serving each other as assistant surgeons. The collectively adopted rule restrained each surgeon's competitive freedom and is thus suspect under the antitrust laws. It is well settled that professional competitors are not free to impose naked horizontal restraints of trade under the rationale that they are ensuring a higher quality of professional services than would be provided under competition. *National Soc'y of Prof'l Eng'rs v. United States*, 435 U.S. 679 (1978).

Although hospital medical staffs clearly serve many procompetitive, efficiency-enhancing purposes within hospitals, their activities pose a variety of dangers to competition and interstate commerce. Their actions should therefore be readily open to antitrust scrutiny to ensure either that the hospital has not given its physicians a greater opportunity than necessary to act anticompetitively or that the physicians have not succumbed

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[15] The assistant-surgeon requirement appears to have been simply a staff-imposed work rule foreclosing independent decisions by surgeons concerning their need for assistance in particular operations. *But see* note 24 *infra*. Whether or not Dr. Pinhas has adequately pleaded the antitrust offense outlined here and its connection to his case, the probable restraint of trade nicely illustrates the need to look beyond effects on a single plaintiff for the nexus between a physician plaintiff's complaint and interstate commerce.

to the temptation. The actions of hospital medical staffs should not be beyond the reach of the federal antitrust laws simply because a particular action directly affects only one competitor among many in the market. The Ninth Circuit's decision in this case should be upheld because the court adequately recognized as a factual matter and "as a matter of practical economics" the wide variety of harms and far-reaching effects that may flow from actions taken in the name of peer review.

B. If this Court should decide that a physician plaintiff seeking to establish jurisdiction in a staff-privileges case must show that the specific violation he alleges affected interstate commerce, then only a small effect should suffice because Congress has the power to protect consumers against the predictable cumulative effect of numerous small abuses and the general competition-inhibiting effect that a medical staff's power has on individual physicians even when it is not exercised.

It may be deemed significant that the price-fixing agreements alleged in both *Goldfarb* and *McLain* were per se offenses under the Sherman Act and were consequently unlawful whether or not there was evidence of actual effects on prices or output. It is at least arguable that this fact alone caused this Court not to require the plaintiffs in those cases to prove that the challenged restraints themselves affected interstate commerce.[16]

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[16] *See McLain*, 444 U.S. at 242 (plaintiffs "need not make the more particularized showing of an effect on interstate commerce caused by the alleged conspiracy to fix commission rates . . . . ").

Certainly it would have been anomalous to require proof of such effects for jurisdictional purposes when, for good policy reasons,[17] no specific effects had to be proved to establish the substantive violation. Staff-privileges cases, however, typically involve conduct that is condemned only under the Rule of Reason, which does require proof that competition was adversely affected. It therefore might seem reasonable in such cases to require plaintiffs also to allege and prove that the violation charged had some impact on interstate commerce.[18]

If this Court should adopt this line of analysis, it nevertheless should instruct the lower courts that staff-privileges cases should not be summarily dismissed on jurisdictional grounds if the particular offense charged has even a slight effect on interstate commerce. Hospital medical staffs are in a position to exercise their power over individual competitors one at a time, perhaps with small effects in any given case but with effects that are cumulatively significant not only in an individual hospital but across communities. Moreover, a medical staff's direct power over individual physicians can inhibit their competitiveness in many ways even when it is not exercised. For these reasons, the court of appeals was correct in basing jurisdiction on the nexus that inevitably exists

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[17] *See, e.g., Northern Pac. Ry. v. United States*, 356 U.S. 1, 5 (1958) (explaining policy rationale for per se rules).

[18] Such reasoning appears to have been the basis for dismissing the complaint in the *Furlong* case, *supra*. *See* note 5 *supra*. Although there is a question in this case whether Dr. Pinhas has made sufficient allegations in this regard, he did allege that he was substantially engaged in interstate commerce and was a victim of an anticompetitive conspiracy.

between the actions of a hospital medical staff and interstate commerce.

In *Klor's, Inc. v. Broadway-Hale Stores, Inc.*, 359 U.S. 207 (1959), the plaintiff's insignificance and failure to allege any general "public harm" were no bar to finding that a substantive violation had been sufficiently alleged. (Jurisdiction was not an issue.) The Court stated that a group boycott "is not to be tolerated merely because the victim is just one merchant whose business is so small that his destruction makes little difference to the economy." *Id.* at 213. The point is well taken, not because antitrust law is designed to protect small business, but because true group boycotts of the kind alleged in *Klor's* are naked restraints that deprive "the marketplace of the independent centers of decisionmaking that competition assumes and demands." *Copperweld Corp. v. Independent Tube Corp.*, 467 U.S. 752, 769 (1984). Although a simple denial of staff privileges in a single hospital is generally not a true boycott deserving similar per se treatment, the potential harm to competition that exists whenever horizontal competitors repeatedly make decisions affecting the fate of other competitors should be enough to establish federal jurisdiction in virtually any case brought by an individual victim.[19]

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[19] For examples of cases that would probably warrant dismissal on jurisdictional grounds even under the test suggested here, see *Stone*, *supra*, and *Sarin v. Samaritan Health Center*, 813 F.2d 755 (3d Cir. 1987).

III. Rather than applying an overly restrictive jurisdictional test, federal courts can deal effectively with nonmeritorious antitrust challenges to hospital actions with respect to staff privileges by applying familiar legal tests for screening allegations of conspiracy and for appraising the operation of procompetitive joint ventures.

An important part of Petitioners' argument is that physicians and hospitals are discouraged from conducting desirable peer review out of fear of incurring heavy expenses in antitrust litigation whether or not they are held liable for treble damages. Although this argument raises a legitimate concern,[20] it proves too much. In addition to downplaying the pervasive threat to competition posed by organized medical staffs, it ignores other means by which lower courts can quickly dispose of nonmeritorious antitrust cases. This is not the only area in which antitrust law must avoid deterring procompetitive behavior while still policing unlawful conduct. Established principles already specifically address the problem

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[20] Indeed, Congress has itself expressed this concern in the Health Care Quality Improvement Act of 1986, 42 U.S.C. § 11101 *et seq*. That legislation, however, leaves hospitals and medical staffs open to antitrust suits for anticompetitive acts, thus showing Congress' awareness of the harms that may be done to competition in the name of peer review. Congress' approach to the problem was not to amend the antitrust laws but to impose pro-defendant fee-shifting in cases where certain conditions protective of competition were met and the action was clearly frivolous. This legislation does not relieve antitrust courts of the need to evolve principles for the just and expeditious handling of these cases.

of unsupportable allegations of vertical or horizontal conspiracy that can be leveled at both procompetitive unilateral conduct and procompetitive joint ventures. These principles allow easy resolution of those staff-privileges cases that challenge hospital actions that truly pose no danger to competition.

This Court has developed a specific test for evaluating pleadings and evidence in cases in which a problematic conspiracy is alleged. In *Monsanto Co. v. Spray-Rite Service Corp.*, 465 U.S. 752 (1984), the Court considered whether dealer complaints to a manufacturer concerning the plaintiff's price cutting – which complaints were followed by the plaintiff's termination – were enough evidence of a vertical price-fixing conspiracy to allow the case to be submitted to the jury. Noting the importance of not chilling a manufacturer's unilateral implementation of a procompetitive marketing strategy employing nonprice restrictions on its dealers, the Court required plaintiffs to produce evidence that is truly probative of an actual conspiracy: "There must be evidence that tends to exclude the possibility that the manufacturer and nonterminated dealers were acting independently." *Id*. at 764. The Court subsequently employed this formula in approving summary judgment for the defendants in *Matsushita Elec. Indust. Corp. v. Zenith Radio Corp.*, 475 U.S. 574, 579 (1986), where it also stated that "conduct that is as consistent with permissible competition as with illegal conspiracy does not, without more, support an inference of conspiracy." *Id*. at 588.

Lower courts are thus well equipped to dispose of antitrust staff-privileges cases on the merits whenever the plaintiff fails to offer evidence that "tends to exclude the

possibility" that the hospital, in taking action against the plaintiff, acted independently in its own interest and not in collusion with its physicians. For example, a plaintiff physician might be required to show, in addition to routine cooperation and communication between the hospital and its medical staff, some reason to doubt that the action taken furthered the hospital's commercial interests (other than by conferring an anticompetitive benefit on physicians).[21] On the other hand, a hospital that could satisfactorily demonstrate that its governing board did in fact take conscientious, independent action having a rational relation to a legitimate corporate interest of the institution – as opposed to merely rubber-stamping a decision of its medical staff – should be shielded from antitrust attack.[22] Under this well-precedented approach, costly discovery and trials would be necessary only if the hospital could not demonstrate that it had not allowed a combination of competitors to act in its stead on matters having grave significance for competition. This Court, in

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[21] Actions that would be against a party's apparent self-interest in the absence of a conspiracy are a classic tip-off that a conspiracy is afoot. *See Theater Enterprises, Inc. v. Paramount Film Distrib. Corp.*, 346 U.S. 537, 541-42 (1954); *Interstate Circuit, Inc. v. United States*, 306 U.S. 208, 226-27 (1939); *Bogosian v. Gulf Oil Corp.*, 561 F.2d 434, 445-47 (3d Cir. 1977), *cert. denied*, 434 U.S. 1086 (1978).

[22] There is a debate among scholars as to the level of antitrust scrutiny to be given to the alleged substantive basis for a hospital's actions. *Compare* Blumstein & Sloan, *supra* note 7, *with* Havighurst, *supra*, note 1, at 1125-39, 1157 n.281 (recommending "limited scrutiny" and a kind of "rational basis" test for action that is clearly unilateral; stressing costliness and deterrent effect of fuller inquiry).

order to respond to legitimate concerns about the high costs of litigating staff-privileges cases, could usefully encourage trial courts to use their authority under Fed. R. Civ. P. 26(d), (f), and 56(f) to limit discovery to the threshold issue of hospital independence until the plaintiff has made a sufficient showing.

Thus, lower courts should be able to dispose of many staff-privileges cases quickly and cheaply (and accurately) without resorting to the expedient of a jurisdictional test that requires a plaintiff to prove the full extent of a conspiracy of which he may not be the only victim. In addition, a rule that exposes to strict, and inevitably costly, antitrust scrutiny only those hospitals that allow physicians to exercise powers properly belonging to the hospital governing board would create a strong incentive for hospital boards to exercise their proper authority and for medical staffs to subordinate themselves to that authority. Such a rule would minimize the risks to competition that inevitably arise when physicians exercise *de facto* control of hospitals. It would also effectively answer hospital and physician complaints that the law deters procompetitive peer review by exposing them to unavoidable litigation costs and unpredictable liability risks.

The Rule of Reason applicable to procompetitive joint ventures supplies additional opportunities for lower courts to screen staff-privileges cases for substantive merit. There are, in reality, two distinct joint ventures present in these cases. Not only is the medical staff a combination of competing physicians, whose actions are subject to the Sherman Act, *Bolt*, 891 F.2d at 819; *Weiss v. York Hosp.*, 745 F.2d 786, 816-17 (3d Cir. 1984), *cert. denied*,

470 U.S. 1060 (1985), but the collaboration between the medical staff and the hospital can itself be characterized as a joint venture.[23] Both joint ventures have strong procompetitive, efficiency-enhancing rationales, however, allowing even actions adversely affecting competition to be justified if they serve significant business interests of the hospital.[24] Because the Rule of Reason supplies tools helpful in distinguishing anticompetitive abuses from reasonable ancillary restraints, lower courts, by screening the pleadings and proof in staff-privileges cases, can quickly dismiss many nonmeritorious cases.[25]

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[23] *See* note 8 *supra*.

[24] For example, the anticompetitive assistant-surgeon requirement at Midway Hospital revealed in Dr. Pinhas's complaint (*see* text at note 15 *supra*) might be defended as a hospital rule that, although maintained on the advice of the medical staff, constituted a procompetitive vertical – rather than an anticompetitive horizontal – restraint. Nevertheless, although it is an issue for trial, it is hard to imagine what business reason the hospital might have had for maintaining such a rule except as a "cat's paw" for its medical staff. *Cf. Valley Liquors v. Renfield Importers, Ltd.*, 678 F.2d 742, 743 (7th Cir. 1982) (supplier induced by distributors to impose a vertical restraint solely for their benefit described by Posner, J., as their "cat's paw"). A possible reason for allowing physicians to operate a cartel on the hospital's premises would be to induce physicians to admit more patients. Such a purpose would be no defense for a vertical conspiracy, however. Incidentally, hospital payments to Dr. Pinhas under the alleged sham consulting contract, being intended to induce referrals of Medicare patients, would violate Medicare fraud and abuse legislation, 42 U.S.C. § 1320a-7b(b).

[25] An essential element in a case under the Rule of Reason is market power. If the hospital is one of many in the market, it

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One principle that has proved valuable in evaluating arguable ancillary restraints of trade adopted by powerful joint ventures is the requirement that the parties design and operate their venture in ways that minimize the hazards to competition that their collaboration creates. In *Silver v. New York Stock Exchange*, 373 U.S. 341 (1963), a powerful combination of competitors engaged in statutorily authorized self-regulation (similar to medical peer review) was held to have violated the Sherman Act in disciplining a competitor without employing fair procedures (which would have minimized the opportunity for anticompetitive abuse). *See also United States v. Realty Multi-List, Inc.*, 629 F.2d 1351, 1369-87 (5th Cir. 1980) (applying less-restrictive-alternative principle to multiple listing service). At a minimum, the less-restrictive-alternative principle applicable to the potentially procompetitive collaboration between a hospital and its medical staff requires close scrutiny of all competition-endangering actions taken by the medical staff as the hospital's agent. *Cf. American Soc'y of Mech. Eng'rs, Inc. v. Hydrolevel Corp.*, 456 U.S. 556, 570-74 (1982) (professional association engaged in product certification held liable for antitrust

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is not clear that the medical staff, by excluding a competitor, can affect the supply of medical services in the market, because the excluded physician may find another institution in which to practice. *See Robinson v. Magovern*, 521 F. Supp. 842 (W.D. Pa. 1981); Havighurst, *supra* note 6, at 1111-16 (focusing on whether hospital is an "essential facility"). *But see* text at notes 14-15 *supra*. By insisting on an early demonstration of the likelihood of market power in a Rule of Reason case, courts can terminate many cases that have no adverse implications for consumer welfare.

violations committed by its voluntary agents). If a hospital can make a satisfactory showing, however, that a particular action affecting competition was its own independent act, taken for legitimate business reasons and not on behalf of or in concert with its physicians, cases should be subject to rapid dismissal. Although scholars differ as to how much of a showing a hospital should be required to make, *see* note 22 *supra*, there is ample opportunity for lower courts to protect conscientious hospitals serving consumer interests from unwarranted burdens in defending their actions on staff-privileges matters.

CONCLUSION

This Court has in this case another opportunity – similar to the one it seized in *Patrick v. Burget*, 486 U.S. 94 (1988) – to prevent antitrust challenges to the anticompetitive acts of hospital medical staffs from being blocked at the courthouse door. In view of the conflict of interests that infects organized physician groups in dealing with issues affecting competition in medical care, it would be inappropriate to focus the jurisdictional inquiry in staff-privileges cases only on the significance or insignificance of the individual plaintiff. As the Ninth Circuit found, there is a high probability that "peer-review proceedings have an effect on interstate commerce."

Respectfully submitted,

CLARK C. HAVIGHURST
c/o Duke University School of Law
Science Drive and Towerview Road
Durham, North Carolina 27706

HAL K. LITCHFORD*
KEVIN D. COOPER
LITCHFORD, CHRISTOPHER &
MILBRATH, P.A.
One duPont Centre
Suite 2200
P.O. Box 1549
Orlando, Florida 32802
*Counsel of Record